Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue
Québec

VD-AT340A

Nom:

Mère: DNA:

Père: Sexe:

RAMQ: Exp: Âge:

Adresse:

Médecin de famille

Screening platform registration form - Agir tôt program

Referral date : 20_____/_____/_____ **Sector :** _____

Child's full name : _____

Folder number ICLSC : _____ **Health insurance number :** _____

Multiple birth ☐ YES ☐ NO **Premature** ☐ YES ☐ NO Number of weeks of prematurity : _____

Vaccination 18 months referral ☐

Referent's full name : _____

Referent's phone number : _____

Reason (s) for referral to the platform / others concerns : _____

_____

_____

Professional involved ☐ YES ☐ NO

Full name : _____

Phone number : _____

Parent's full name / Respondent : _____

Relationship to child : _____

Parent's phone number / Respondent : _____

Parent's e-mail address / Respondent : _____

Need support to complete the questionnaires ☐

Referent's name : _____ **License number (if applicable) :** _____

Date : 20_____/_____/_____
Year Month Day

Foward by fax **819 732-1429**
or by e-mail address **08.cisssat.info.agir.tot@ssss.gouv.qc.ca**

Contact information : **1 833 602-2447**